Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Municipality Insurance Enrollment and Change Form (FORM -1MUN)

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
___ ___		/ /	666/

Name - Last First MI

Address ☐ This is a new address	City	State	Zip Code

Date Entered Service	City or Town employed or retired from	Home Phone	Work Phone
/ /		( )	( )

02 ☐ **HEALTH COVERAGE** **Effective Date: / 01 /**

New Enrollment ☐ Change ☐ Cancel Coverage ☐

☐ **Health** (Select one of the health plans below and individual or family coverage)

Health Plan – Active Employees and Non-Medicare Retirees

- ☐ Fallon Direct
- ☐ Fallon Select
- ☐ Harvard Pilgrim Independence
- ☐ Health New England
- ☐ Navigator by Tufts Health Plan
- ☐ NHP Care – Neighborhood Health Plan (HMO app required)
- ☐ UniCare State Indemnity/Basic CIC: ☐ Yes ☐ No
- ☐ UniCare/Community Choice
- ☐ UniCare/PLUS

Coverage
☐ **Individual**
☐ **Family**

03 ☐ **Name Change** | Previous Name | New Name

INSURED CHANGES **FOR GIC USE ONLY:** **Effective Date: / 01 /**

06 ☐ **Retirement** Date Retired / /

07 ☐ **Transfer to another Agency** Name of Agency Transferred to Effective Date / /

08 ☐ **Transfer from another Agency** Previous Agency Effective Date / /

09 ☐ **Termination Coverage (if elected)** Termination Reason _____

Termination Date _____/_____/_____

☐ 39 -Week Layoff Coverage ☐ Deferred Retiree ☐ COBRA (must complete COBRA application) ☐ Conversion (contact carrier for application)

SIGNATURE REQUIRED

Deduction Authorization

I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.

At Retirement

I hereby certify that I have filed an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage.

Termination

I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.

• If you are applying for Health Insurance, be sure to file a Form IDF to list family members • If you are enrolling in an HMO that requires a seperate application, be sure to file an application with the Plan.

x _____ Signature of Applicant Date

x _____ Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision

ACTIVE AND RETIRED EMPLOYEES: RETURN COMPLETED FORM TO YOUR GIC COORDINATOR AT YOUR CITY/TOWN BENEFITS OFFICE. DO NOT RETURN TO THE GIC

FORM 1MUN 3/08 5,000

Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Employee Acknowledgement Form

You are responsible for familiarizing yourself with your benefit options:

- Health Insurance
- Pre-tax Health Insurance Benefits (Section 125 Plan)

Your signature is required on this form before your agency can process your benefit elections. Please sign, date and return this form to your GIC Coordinator after you have reviewed the *Benefit Decision Guide*. (Or for visually impaired employees, have listened to the BDG audiotape.)

I hereby acknowledge that I have reviewed the most recent *GIC Benefit Decision Guide* before I made my benefit elections.

Name: _____

(Please print)

Signature: _____

Social Security Number: _____

Date: _____

Employee: Return this signed form to your GIC Coordinator/Benefits Office with your benefit elections.
GIC Coordinator: Retain original signed form in employee s personnel file.

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INSURANCE DATA FORM (IDF)

PLEASE PRINT CLEARLY

This form is required for new enrollments in any Group Insurance Commission family health plan and for any changes in spouse or dependents. Complete it and any other health plan forms provided by your Group Insurance Coordinator and return them to the Coordinator. If you are a retiree, please return the form to the GIC. Please PRINT clearly. Incomplete forms will be returned.

CHECK ONE: ☐ **NEW MEMBER** ☐ **ADDITION** ☐ **DELETION** ☐ **CORRECTION**

Important: You are required to provide a copy of a marriage certificate, birth certificate, separation agreement, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. Failure to provide this documentation will result in your spouse/dependent not being covered. If you are deleting a spouse or dependent under age 19, you must provide proof of other coverage.

INSURED INFORMATION

1) Social Security Number _____ 2) Date of Birth ___/___/___ (Month / Day / Year) 3) Sex ☐ M ☐ F

4) Name _____
Last First Middle

5) Address _____
Street

_____
City State Zip Code

6) Are you enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim # _____

7) Health Plan (Check one)
☐ Fallon Direct ☐ Health New England ☐ UniCare State Indemnity/Basic ☐ Medicare Plan
☐ Fallon Select ☐ Navigator by Tufts Health Plan ☐ UniCare/Community Choice Fill in name of Medicare
☐ Harvard Pilgrim Independence ☐ NHP Care – Neighborhood Health Plan ☐ UniCare/PLUS Plan: _____

SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse, who will be covered under your family plan. Married children are not eligible. Please provide all Social Security Numbers and **exact** dates of birth for each dependent. Attach separate sheet if additional space is required. Coverage for children ends at age 19; to continue their coverage you must complete and return to the GIC a Dependent Age 19 and Over Application for Coverage.

Last Name	First	Middle	Relationship	Date of Birth	Sex	Social Security Number

Reason for addition or deletion: _____ Effective date: _____

SPOUSE INFORMATION

Is your spouse employed? ☐ Yes ☐ No Name of employer _____ Address of employer _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No Name of insurance company _____

Policy/Certificate Number _____ Address of insurance company _____

Are you and/or your children covered under your spouse's group health insurance plan? You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim number _____

FORMER SPOUSE

Name _____ Social Security Number _____ Date of Birth _____ Date of Divorce _____
Last First Middle

Address _____
Street City State Zip Code

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

IMPORTANT: YOU MUST SIGN BELOW

Signed under the pains and penalties of perjury, I certify that the information I have provided is, to the best of my knowledge, complete and accurate.

Signature _____ Date _____

ACTIVE EMPLOYEES: RETURN COMPLETED FORM TO YOUR GIC COORDINATOR. **RETIREES**: RETURN COMPLETED FORM TO THE GIC

Form IDF 3/08 10,000

FOR GIC COORDINATOR USE ONLY **Dept. ID # or Agency/Division #** _____

Name of GIC Coordinator _____ Agency Telephone Number _____

Agency Name _____

Agency Address _____

FOR GIC USE ONLY

Entered _____

Verified _____

Date _____

Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Dependent Age 19 or Over Application for Coverage Instructions

YOU MUST COMPLETE THE ATTACHED FORM IN ORDER TO ENROLL YOUR DEPENDENT IN GIC COVERAGE IF THE DEPENDENT IS ELIGIBLE. If you do not complete the application, your dependent will have no GIC coverage.

Please keep in mind the following:

- Coverage for a dependent who is turning 19 ends on the last day of the month in which the dependent turns 19, unless the form is completed and returned to the GIC.
- Dependents who qualify as dependents under Internal Revenue Service (IRS) rules are eligible for coverage up to age 26 or two years after losing dependent status according to IRS rules, **whichever occurs first**.
- For current insureds, continuous coverage will be allowed after the 19th birthday if the GIC receives a Dependent Age 19 or Over Application for Coverage within 30 days of the 19th birthday. Applications received at the GIC more than 30 days after the dependent's 19th birthday will have coverage beginning on the first day of the second month after receipt of the application.
- For new insureds, coverage for the dependent aged 19 and over will begin on the new insured's coverage effective date if he/she submits a completed dependent application before the insured's effective date of coverage. Applications received after the insured's effective date of coverage will be processed with a later effective date.
- Full-time student dependents must attend an accredited school.
- Dependents age 19 to 26 who are not full-time students or handicapped dependents may be eligible for continued coverage.
- You will be subject to imputed income on the full cost individual premium for the health plan in which you are enrolled for each Non-IRS Dependent covered under your policy.
- Fulltime students age 26 and over are not eligible for continued coverage if there has been a two year break in coverage with the GIC after the student has reached age 26.
- The GIC will determine coverage eligibility and effective dates.
- The insured must have family plan coverage.
- Your health plan or the GIC will contact you periodically to verify your dependent's continued eligibility. **IF YOU DO NOT RESPOND TO THESE VERIFICATION REQUESTS, YOUR DEPENDENT'S COVERAGE WILL BE TERMINATED.**

Instructions:

- If your dependent is a full-time student age 19 to 24, complete Sections 1 and 2;
- If your dependent is a full-time student age 24 and over, complete Sections 1, 2 and 4 **or** 5;
- If your dependent is mentally or physically incapable of earning his/her own living and has been so prior to age 19, OR became permanently and totally disabled on or after age 19 and is under age 26, complete Sections 1 and 3;
- A copy of the dependent's certified birth certificate is required for all new dependents.

INSTRUCTIONS CONTINUED ON OTHER SIDE

Dependent Age 19 or Over
Application for Coverage
Instructions (Continued)

You must notify the GIC when your dependent:

- Is no longer a full-time student at an accredited school;
- Withdraws from school;
- Is on a medical leave of absence from school or the medical leave of absence ends;
- Graduates
- Ceases to be an IRS dependent; or
- Ceases to be a Non-IRS dependent

Failure to do so may result in financial penalties.

If one of these events occurs and your dependent is eligible for continued coverage, you can apply for continued coverage by completing another "Dependent Age 19 and Over Application for Coverage", or you may apply for COBRA coverage.

- For clarification of Internal Revenue Service (IRS) rules for dependents, contact the IRS or a tax professional as they are the tax experts. Do not contact the GIC.
- We can only accept original applications, not photocopies or faxed transmittals. **Keep a copy of this application for your records.**

Questions?
617.727.2310
www.mass.gov/gic

Commonwealth of Massachusetts
Group Insurance Commission

DEPENDENT AGE 19 OR OVER APPLICATION FOR COVERAGE

PLEASE PRINT AND ANSWER ALL QUESTIONS, SIGN THE COMPLETED FORM AND SEND IT TO THE GIC.

SECTION 1. INSURED/DEPENDENT INFORMATION

Name of Insured_____ Insured's Social Security #_____-_____-_____

Address_____Telephone Number (_____)_____

City/State_____ Zip code_____

Place of Employment_____

Name of Dependent_____ Dependent's Social Security #_____-_____-_____

Relationship to Insured_____ Dependent's Date of Birth_____/_____/_____

My dependent is one of the following *(check one and complete corresponding sections)*:

_____ Full-time student age 19 to 24 *(complete Section 2)*

_____ Full-time student age 24 to 26 *(complete Sections 2 and 4* **OR** *5)*

_____ Full-time student age 26 and over *(Complete Section 2; you will be charged the full cost premium for this coverage.)*

_____ Part-time student *(complete Sections 2, and 4* **OR** *5)*

_____ IRS Dependent Age 19 to 26 other than a full-time student *(complete Section 4)*

_____ Non-IRS Dependent Age 19 to 26 *(complete Section 5)*

_____ Handicapped dependent *(complete Section 3 and apply for coverage with a GIC Handicapped Dependent Application.)*

SECTION 2. STUDENT INFORMATION

The above dependent student has been accepted or is currently enrolled in the educational school listed below:

Name of Student's School *(Must be an Accredited School if Full-time Student)*_____

Address of School_____

City, State, Zip _____

Date Admitted _____/_____/_____ Expected date of graduation: Month_____ Year _____

Is your dependent student a full-time student? Yes _____ No _____

Is your dependent student a part-time student? Yes ____ No _____

Is your dependent student on a medical leave from school? Yes_____ No _____

If yes, please give dates of leave: From _____/_____/_____ To _____/_____/_____

I understand that I must notify the GIC when my dependent's student status changes (part-time to full-time, or full-time to part-time), withdraws from school, is placed on a medical leave of absence from school, returns from the medical leave of absence, or graduates. I also understand that my health plan or the GIC may, at times, verify my dependent's student status by contacting the school that my dependent attends. **Under the pains and penalties of perjury, I attest that all statements I have made on this form are true. I understand that if I misrepresent or provide false or incomplete information on this form, my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies, at the GIC's discretion**.

Signature of Insured _____ Date _____

Commonwealth of Massachusetts
Group Insurance Commission

DEPENDENT AGE 19 OR OVER APPLICATION FOR COVERAGE (continued)

SECTION 3. HANDICAPPED DEPENDENT COVERAGE

My handicapped dependent named in Section 1 is either *(check one)*:

_____ mentally or physically incapable of earning his/her own living and has been so prior to age 19; OR
_____ permanently and totally disabled and became so on or after age 19 and is under age 26.

I understand that I must complete the GIC's *Handicapped Dependent Coverage* application, available from the GIC.

Signature of Insured _____ Date _____

SECTION 4. IRS DEPENDENT AGE 19 to 26 COVERAGE

My dependent named in Section 1 is a dependent under IRS rules. I have claimed or will claim him/her as an exemption on my federal tax forms filed with the Internal Revenue Service (IRS) for the following calendar years **(must answer for all three years):**

Calendar Year 2006 Yes ____ No _____
Calendar Year 2007 Yes ____ No _____
Calendar Year 2008 Yes ____ No _____

Under the pains and penalties of perjury, I attest that all statements on this form are true. I further understand that if I misrepresent or provide false or incomplete information, my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies, at the discretion of the GIC.

Signature of Insured _____ Date _____

SECTION 5. NON-IRS DEPENDENT AGE 19 to 26 COVERAGE

My dependent named in Section 1 is not a dependent under IRS rules, but I want to continue coverage for him/her up to age 26 OR two years after losing dependent status, whichever occurs first. I understand that there are income tax consequences to me. I have stopped or will stop claiming him/her as an exemption on my federal tax forms filed with the Internal Revenue Service (IRS) for calendar year (please answer for all three years):

Calendar Year 2006 Yes ____ No _____
Calendar Year 2007 Yes ____ No _____
Calendar Year 2008 Yes ____ No _____

Under the pains and penalties of perjury, I attest that all statements on this form are true. I further understand that if I misrepresent or provide false or incomplete information, my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies, at the discretion of the GIC.

Signature of Insured _____ Date _____

SECTION 6. MAILING INSTRUCTIONS

Send completed application to: Group Insurance Commission, Continued Coverage Unit, P.O. Box 8747, Boston, MA 02114-8747

FOR GIC USE ONLY

Approved _____ Effective Date _____/_____/_____ Expiration Date _____/_____/

Denied _____ Reason _____

Reviewed by _____ Date_____/_____/_____

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

The Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747
Boston, Massachusetts 02114-8747

(617) 727-2310
Fax (617) 227-2681
TTY (617) 227-8583
www.mass.gov/gic

Original _____

Renewal _____

Dear Insured:

We have received the request for your daughter s/son s handicapped dependent coverage.

Please note that in order for a dependent to apply for handicapped dependent coverage, he or she must meet one of the following conditions:

- 〈 became mentally or physically incapable of earning his/her own living prior to age 19; or
- 〈 became permanently and totally disabled and became so on or after age 19 and is under age 26.

If your dependent meets one of these two requirements, we have listed below information for you to return to the GIC so that a decision can be made on your application. If your dependent is working, please include a copy of his/her latest earnings statement.

INFORMATION FROM THE INSURED PARENT

The insured parent must complete the *Statement From Insured Parent For Handicapped Dependent Coverage* (page 1 of 2). Please answer all questions completely so that we can process your application as quickly as possible.

INFORMATION FROM THE DEPENDENT S PERSONAL PHYSICIAN

Please have the Physician s Statement (page 2 of 2) completed by the dependent s personal physician; the physician must be licensed to practice medicine in Massachusetts or the state in which you reside.

Please return the entire completed application to us (no fax transmittals or photocopies accepted). We shall try to have a response to you within four to six weeks of receiving your completed application. If you have any questions concerning this application, contact us at (617) 727-2310, extension 5.

Sincerely,
Continued Coverage Unit
Group Insurance Commission

STATEMENT FROM INSURED PARENT FOR HANDICAPPED DEPENDENT COVERAGE

This form will be returned if it is not fully completed.

Full Name of Dependent _____

Dependent s Date of Birth_____ Dependent s Soc. Sec. Number _____

Dependent s Address _____

City_____ State _____ Zip Code_____

Dependent s Marital Status _____

Full Name of Insured _____

Insured s Address _____

City _____ State_____ Zip Code _____

Insured s Social Security Number _____

Date Dependent Became Totally Disabled _____

If the dependent is over age 19, have they had health insurance coverage from age 19 to the present?

YES _____ NO _____

If *YES,* please provide the following:

Name of Insurance Carrier _____

Name of Employer _____

The effective date of coverage _____

Is coverage still in effect? Yes _____ No _____

If NO, when was coverage cancelled and why? _____

If NO, please provide the following:

Did the dependent incur any medical expenses during the time there was no health insurance coverage?

YES_____ NO _____

If YES, how were the medical expenses paid?_____

Is your dependent eligible for Medicare Benefits? Yes____ No ___ Never Applied for Medicare _____

If YES, please include a photocopy of the Medicare Claim Card

If NO, please include a letter from your local Social Security Office advising of the reason the dependent is not eligible for Medicare benefits.

Please read and sign the following statement and if the dependent is capable, please also have the dependent sign.

I hereby apply for handicapped dependent coverage and agree to periodic independent physician examinations as requested by the GIC. I hereby certify under the pains and penalties of perjury that the foregoing statements are true, based upon my knowledge and belief.

Signature of Insured Parent_____ Date _____

Signature of Dependent _____ Date _____

PHYSICIAN S STATEMENT FROM ATTENDING PHYSICIAN

Note: this form will be returned if not fully completed.

Insured Parent s Name _____

Name of Patient _____

Patient s diagnosis and date of illness _____

(a) Is the patient currently working? YES _____ NO _____

(b) Is the patient currently capable of self support YES _____ NO _____

(c) If NO to question b is there any potential that the patient will eventually be capable of self-support?

YES _____ NO _____

(d) If YES to question c, please provide your best estimate of when the patient will be capable of self-support. _____

Date of onset of disability (the inability to support themselves). _____

How long have you been treating this patient for the diagnosis indicated above? State other diagnosis if necessary.

Include first and most recent visits. _____

_____

_____

_____

Describe your treatment plan including a prognosis and goals for this patient in as much detail as possible and, if the patient is enrolled in a vocational training, rehabilitation or similar program, include goals and timetables that have been established for the program. (Attach other sheets as necessary.)

_____

_____

_____

_____

I hereby attest under the penalties of perjury that the above information is true, based on my knowledge and belief

Physician s Signature _____ Date _____

Physician s Data (please print or type the following information): _____

Name _____ Specialty _____

Address _____ City _____ State _____ Zip Code _____

Telephone No (_____)_____

Insured: Mail pages 1 and 2 of this form to the GIC at the address below. Keep a copy for your records.

Commonwealth of Massachusetts Group Insurance Commission
P.O. Box 8747
Boston, MA 02114-8747